Exhibit 9

AUTHORIZATION FOR RELEASE OF MEDICAL & BILLING INFORMATION

TO: The physician, psychologist, hospital, medical provider, insurance company, private or third party payor, and/or their custodians of records:

This is authority for you to furnish to **YVONNE K. PUIG, Fulbright & Jaworski L.L.P., 98 San Jacinto Blvd., Suite 1100, Austin, Texas, 78746**, any of her legal associates, or anyone whom she may designate as her investigative agent, upon presentation of this authorization, all information, including but not limited to medical, billing and/or business records, concerning the past, present, or future physical, emotional and mental health condition of_____ ("Patient"), including full disclosure of all hospitalizations, treatments, medical records, reports, diagnostic studies, x-rays, histories, charts, and any other documentation, as well as information concerning costs and expenses incurred for treatment. This authorization is further intended to specifically include disclosure of records pertaining to psychiatric, psychological, sexual abuse/assault, and/or drug or alcohol abuse treatment.

The release of the matters listed above is being authorized for purposes of compliance with discovery in a lawsuit that has been transferred by the Judicial Panel on Multidistrict Litigation to the United States District Court for the District of Massachusetts as part of an MDL, styled IN RE NEW ENGLAND COMPOUNDING PHARMACY, INC. PRODUCTS LIABILITY LITIGATION, No. No 1:13-md-2419 (FDS). In the Patient's individual lawsuit, the mental, physical, and/or emotional condition of the Patient has been placed in issue and is relevant to the claims and/or defenses of the litigants.

The undersigned understands that, with respect to this Authorization:

- the signing of this Authorization is strictly voluntary;
- treatment, enrollment, or eligibility for, or payment of, benefits may not be conditioned upon the signing of this authorization;
- the released information may not be protected by federal privacy regulations and may be redisclosed in conjunction with this litigation;
- the undersigned is entitled to examine and/or obtain a copy of the information described in this Authorization, for a reasonable copy fee, if requested from the covered entity receiving this Authorization; and
- the information released may consist of information regarding alcohol, drug abuse, psychiatric evaluation, HIV testing and results, or information about AIDS.

This authorization is subject to revocation by the undersigned, if said revocation is in writing addressed to **YVONNE K. PUIG**, or her agent or representative, at any time except to the extent that action has been taken in reliance on it, and if not earlier revoked, shall terminate at the conclusion of **Cause No. No 1:13-md-2419 (FDS)** in the United States District Court for the District of Massachusetts. Details regarding the rights of revocation and any exceptions may be found in the Notice of Privacy Practices. A photostatic copy of this Authorization is as valid and binding as an original executed by the undersigned. This authorization complies with 45 CFR 164 regarding the core elements of an authorization pursuant to HIPAA.

The undersigned acknowledges that he/she is the individual whose protected health information is being released, or is a person authorized to act on that individual's behalf.

I have read the above and authorize the disclosure of the protected health information as stated.

_____ _____

[Signature of Patient or Representative] **[Date of Authorization]**

_____

[Print Name of Patient or Representative]

Social Security Number of Patient _____

Date of Birth of Patient _____

If executed by a Representative, state the relationship of Representative to Patient:_____

_____ _____

[Witness Signature] **[Date]**